

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/22/2008
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29C0001018		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/22/2008	
NAME OF PROVIDER OR SUPPLIER DIGESTIVE DISEASE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 2136 E DESERT INN RD #B LAS VEGAS, NV 89109			
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Q 000	<p>INITIAL COMMENTS</p> <p>This Statement of Deficiencies was generated as a result of a Medicare recertification survey conducted at your center on April 21-22, 2008.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p> <p>Twenty clinical records were reviewed.</p> <p>The center failed to maintain condition level compliance with the following Conditions of Coverage:</p> <p>42 CFR 416.41 Governing Body and Management 42 CFR 416.43 Evaluation of Quality 42 CFR 416.44 Environment 42 CFR 416.45 Medical Staff</p> <p>The following regulatory deficiencies were identified:</p>			Q 000			
Q 003	<p>416.41 GOVERNING BODY AND MANAGEMENT</p> <p>The ambulatory surgical center must have a governing body that assumes full legal responsibility for determining, implementing, and monitoring policies governing the center's total operation and for ensuring that these policies are administered so as to provide quality health care in a safe environment. When services are provided through a contract with an outside resource, the center must assure that these services are provided in a safe and effective</p>			Q 003			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Q 003	Continued From page 1 manner. This CONDITION is not met as evidenced by: The center failed to ensure the governing body assumed full legal responsibility for determining, implementing and monitoring policies governing the center's total operation and for ensuring that the policies were administered so as to provide quality health care in a safe environment (Q003); failed to ensure the ASC (ambulatory surgery center), with the active participation of the medical staff, conducted an ongoing, comprehensive self-assessment of the quality of care provided, including medical necessity of procedures performed and appropriateness of care, and use findings, when appropriate, in the revision of center policies and consideration of clinical privileges (Q009); failed to ensure the ASC had a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients (Q010); and failed to ensure the medical staff at the ASC was accountable to the governing body (Q019). The cumulative effect of these systemic practices resulted in the failure of the center to deliver statutory mandated patient care.	Q 003			
Q 009	416.43 EVALUATION OF QUALITY The ambulatory surgical center, with the active participation of the medical staff, must conduct an ongoing, comprehensive self-assessment of the quality of care provided, including medical necessity of procedures performed and appropriateness of care, and use findings, when appropriate, in the revision of center policies and consideration of clinical privileges. This CONDITION is not met as evidenced by:	Q 009			

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Q 009	<p>Continued From page 2</p> <p>Based on interview and policy review, the center failed to ensure the quality improvement program was implemented per the center's policies.</p> <p>Findings include:</p> <p>1. The center's "Review of the Joint Committee Meeting" manual was reviewed on 4/21/08. The manual contained the following:</p> <p>a. Quality Improvement Minutes b. Peer Physician Review Quarterly c. Letters of Agreement d. Quality Quarterly e. Generator Check</p> <p>The center's Quality Improvement (QI) policy documented the Chief Executive Officer (CEO) was responsible for the monitoring of the activities of the Quality Improvement program. This was verified on 4/21/08 at 9:15 AM, during an interview with the Nurse Manager. The Nurse Manager indicated the Governing Body convened quarterly.</p> <p>The Quality Improvement Quarterly program was established to monitor the following:</p> <p>a. Medical record reviews b. Peer Review c. Infection Control d. Equipment maintenance e. Patient satisfaction survey</p> <p>The policy in the "Review of the Joint Committee Meeting" manual documented the Quality Improvement and Peer Physician Review members were expected to meet quarterly.</p>	Q 009			

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Q 009	<p>Continued From page 3</p> <p>Review of the Peer Physician Review quarterly reports minute recordings starting on 1/12/06 with the last entry dated 5/10/07. To date, no other minute recordings were located within the manual.</p> <p>Review of the medical record review quarterly reports lacked documented evidenced of minute recordings after the first quarter of 2007. To date, no other minute recordings were located within the manual.</p> <p>Review of the Infection Control quarterly reports revealed no minute recordings after the second quarter of 2007. To date, no other minute recordings were located within the manual.</p> <p>Review of the equipment maintenance quarterly reports revealed no minute recordings after the second quarter of 2007. To date, no other minute recordings were located within the manual.</p> <p>In addition, review of the center's policies evidenced specific policies which had marked out sections throughout the documents, including sections with hand written edits. The policies were dated 1992 and 1993.</p> <p>2. On 4/21/08 at 9:15 AM, during an interview with the Nurse Manager, the Nurse Manager confirmed the policies were outdated and the above quarterly reports were non-existent within the manual.</p> <p>When asked about the center's Infection Control program and the process for reporting surgical complications, the Nurse Manager indicated the CEO notified the Nurse Manager of possible surgical issues or complications when the</p>	Q 009			

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Q 009	Continued From page 4 patients were seen in the physician's office for their follow-up visits. When there were surgical complications, the information was collected on a form located in the patients' medical records. The Nurse Manager further indicated the reported data was not collected for the QI Committee tracking and trending purposes of surgical complications. According to the center's "Review of the Joint Committee Meeting" policy the Quality Improvement and Peer Physician Review members were expected to meet quarterly. There was no documented evidence the quarterly meetings occurred as stated within the policy. Furthermore, there was no documented evidence to support the center conducted on-going, comprehensive self-assessment per their policies and procedures, or as required by regulation. Moreover, there was no documented evidence presented to support the QI program, or the policies and procedures had been reviewed or updated since the center initially opened in 1993. One policy was dated 1992, prior to the establishment of the center.			Q 009			
Q 010	416.44 ENVIRONMENT The ambulatory surgical center must have a safe and sanitary environment, properly constructed, equipped, and maintained to protect the health and safety of patients. This CONDITION is not met as evidenced by: The center failed to ensure a safe and sanitary environment, properly constructed, equipped, and maintained was provided to protect the health and safety of patients (Q010); the center failed to ensure a sanitary environment was provided for the provision of surgical services (Q011); failed to ensure a competency checklist was completed for			Q 010			

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Q 010	<p>Continued From page 5</p> <p>a surgical technician as part of the infection control program (Q014); failed to ensure the center had a functioning mechanical ventilator on the premises (Q016).</p> <p>The cumulative effect of these systemic practices resulted in the failure of the center to deliver statutory mandated patient care.</p> <p>Based on observation and interview, the center failed to ensure a clean and sanitary environment was maintained.</p> <p>Findings include</p> <p>On 4/21/08 at 10:05 AM during the tour of the surgical/procedure room area, the floor tiles appeared unclean and unpolished. The clean utility, pre-op and procedure rooms were cluttered with numerous items such as emptied boxes, intravenous poles and other boxes full of surgical supplies.</p> <p>1. At 10:05 AM during a colonoscopy observation in the procedure room, the tall garbage container located between the dirty utility room door and the procedure room cabinets was observed overflowing with soiled items. A metal stand table was positioned above the garbage container which was draped with a blue under pad Chux. The patient's medical forms were placed on top of the blue under pad. The edges of the blue under pad were observed touching the soiled items in the garbage container during the scope procedure.</p> <p>2. Immediately following the endoscopic procedure, the technician took the scope to the adjacent dirty utility room for decontamination. A large, red plastic container was on the floor and</p>			Q 010			

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Q 010	<p>Continued From page 6</p> <p>labeled biohazard. A patient's medical form was observed on top of the closed lid of this biohazard container. The technician was observed during the cleansing of the scope to drop soiled tubing and other items into this biohazard container. The technician was observed during this process handling the medical form with soiled gloves. After the scope cleaning process, the surveyor inquired about the medical form on top of the biohazard container. The technician stated it was the patient's pathology form. The technician explained if a specimen was not collected during the endoscopic procedure then the form was placed on top of the biohazard container for shredding at a later time.</p> <p>The placing of medical forms on top of the biohazard container including the handling of the forms with soiled gloves had the potential for cross-contamination to other areas of the center when these forms were taken out of the dirty utility room to be shredded.</p> <p>3. On 4/21/08 at 3:20 PM, during an observation of the small dirty utility room it revealed a large amount of piled up soiled items against the door that led to the post recovery room. The soiled items were stacked between the biohazard container and the end of the cabinet. It was approximately three feet high by four feet long and three feet wide. One trash container was filled with soiled items that came up to the level of the door knob. The other two trash containers were also over flowing with soiled items and obstructed the pathway between the two wall cabinets on each side of the small room. Five large plastic emptied bottles were arranged around the two over-flowing trash cans. The three trash containers were filled with soiled aprons,</p>	Q 010			

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Q 010	Continued From page 7 rubber gloves, plastic tubing, paper wrappings and other items. A clean box of rubber gloves on the counter was only an inch or so away from the soiled items in the trash container that was against the door. 4. During an interview with Nurse Manger at 3:20PM, the Nurse Manager indicated the facility was opened on Saturday and the center had performed fifteen procedures. The soiled items were for a two days period. This condition created and unsafe and unsanitary environment and had the potential for cross contamination and infection.			Q 010			
Q 011	416.44(a) PHYSICAL ENVIRONMENT The ambulatory surgical center must provide a functional and sanitary environment for the provision of surgical services. This STANDARD is not met as evidenced by: Based on observation and interview, the center failed to ensure a sanitary environment was provided for the provision of surgical services. Findings include: Observations 1. On 4/21/08, during the center tour in the morning, the clean utility room had boxes of sterile supplies stored on the floor. There were boxes of syringes sitting on the floor, and an assortment of other boxed supplies, as well as oxygen tanks, unlocked medical records, and dirty mops stored within the clean utility room. 2. On 4/21/08, during the center tour in the morning, five colon endoscopes were hanging in			Q 011			

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Q 011	<p>Continued From page 8</p> <p>the closet in the hallway next to the pre-operative area and were touching towels placed on the floor to absorb possible moisture draining from the endoscopes as they were drying. There were yellow dime sized stains where the endoscopes touched the towels. There was a dirty partial footprint observed on the towel.</p> <p>3. On 4/21/08, during observation of a colonoscopy procedure in the morning, the surgical technician, after removing the biopsy sample from the snare, placed the used coiled up snare under the gurney mattress and onto the gurney bed frame following the removal of the colon biopsy. The snare was needed for another colon biopsy and was pulled from under the mattress and inserted back into the patient to remove another biopsy sample. The surgical technician removed the biopsy sample and then coiled up the snare and placed it under the gurney mattress. There were 3 biopsies obtained during the procedure and between each biopsy, the snare was stored between the gurney mattress and the gurney bed frame.</p> <p>4. On 4/21/08, during observation of a colonoscopy procedure in the morning, the surgical technician placed a chart form under the biopsy container. The biopsy container was filled approximately 3/4 full with Formalin. The surgical technician vigorously shook the biopsy sample loose from the snare and splashed the Formalin onto the chart paperwork, contaminating the paperwork, which was then placed into the patient's chart.</p> <p>Interview</p> <p>During an interview with the Nurse Manager on</p>	Q 011			

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Q 011	<p>Continued From page 9</p> <p>4/21/08 in the morning, it was revealed the storage space was very limited at the center. The Nurse Manager stated the supplies arrived in boxes from warehouses where they were stored on the floor and the boxes at the center were not opened yet and therefore, could be stored on the floor.</p> <p>The Nurse Manager stated the medical record cabinets in the room had locks on the cabinets, but were unable to be locked because there were large quantities of records protruding from the cabinets which prevented the cabinets from being closed. There was not a lock on the clean utility door which per the nursing manager would be corrected as soon as possible to assure safe storage and confidentiality of the medical records.</p> <p>The mops were removed by the Nurse Manager immediately when discovered during the tour.</p> <p>The Nurse Manager stated a stainless steel shelf with a drain was going to be installed in the hallway closet where the endoscopes were stored and hanging, so the endoscopes would no longer be touching towels on the floor. The stainless steel shelf could then be wiped down with germicide rather than using towels to absorb the moisture and prevent staff from stepping onto the towels and contaminating the clean area. The Nurse Manager also stated the closet was large enough in height and the endoscopes could be hung higher so they were not touching the floor or the new shelf.</p> <p>The Nurse Manager stated the snares following a biopsy procedure were stored under the gurney mattress because of the limited space in the procedure room and the gurney mattress and</p>			Q 011			

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Q 011	<p>Continued From page 10</p> <p>gurney bedframe were cleaned with germicidal wipes between each patient following post-operative recovery, therefore, preventing transmission of any bacteria or germs from the snares which touched the mattress bottom and gurney bedframe.</p> <p>The nurse manager stated chart paperwork would be placed on a hook above the surgical technician's work area to prevent any Formalin and potential splashing and contamination and this was to be done immediately.</p> <p>During an interview on 4/22/08 with the Registered Nurse (RN) in the post-operative recovery area, it was revealed the gurney frame was not always completely cleaned between each patient and sometimes only the rails of the gurney were cleaned and not the gurney frame where the mattress touched the bottom of the gurney frame. The RN stated both sides of the mattress were cleaned with germicidal wipes.</p> <p>5. On 4/22/08 at 3:30 PM during an observation with the Nurse Manger in the procedure and recovery rooms, the emergency call light cable was observed laying on top of the counter in the recovery room and unplugged. The Nurse Manager after searching for a connecting port was unable to find it. The Nurse Manager did not know where to plug the end of the emergency call light cable. The Nurse Manager stated "I guess, we don't have one".</p> <p>In the procedure room was an intercom on the wall by the door way. The Nurse Manager pushed several buttons on the pad. A sound was heard by the nursing station. The Nurse Manager was unsure how to activate the emergency alarm</p>	Q 011			

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Q 011	Continued From page 11 sound. The Nurse Manager stated in the past they had pushed one of the buttons on the intercom by the nursing station and the alarm had gone off. The Nurse Manager did not want to repeat this incident because she would not know how to shut it off. The center did not have a working emergency alarm system in place. In addition, the staff was unable to activate the system in case of an emergency.	Q 011			
Q 014	416.44(a)(3) ELEMENT of STANDARD PHYSICAL ENVIRONMENT The ambulatory surgical center must establish a program for identifying and preventing infections, maintaining a sanitary environment, and reporting the results to appropriate authorities. This ELEMENT is not met as evidenced by: Based on record review, the center failed to ensure as part of the infection control program, a competency skills checklist was completed for one surgical technician (#1). Findings include: Employee #1's personnel file did not contain a completed competency skills checklist. The form was in the file, but was blank. There was not a signed job description and there was no evidence of inservice education completed.	Q 014			
Q 016	416.44(c) EMERGENCY EQUIPMENT Emergency equipment available to the operating rooms must include at least the following: o Emergency call system. o Oxygen. o Mechanical ventilatory assistance equipment including airways, manual breathing bag, and	Q 016			

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Q 016	Continued From page 12 ventilator. o Cardiac defibrillator. o Cardiac monitoring equipment. o Tracheostomy set. o Laryngoscopes and endotracheal tubes. o Suction equipment. o Emergency medical equipment and supplies specified by the medical staff. This STANDARD is not met as evidenced by: Based on observation and interview, the center failed to ensure a mechanical ventilator was on the premises. Findings include: Observation During the facility tour on 4/21/08 in the morning, the mechanical ventilator was not present in the center. Interview During interview on 4/21/08 in the morning with the Nurse Manager, it was revealed the mechanical ventilator had been recently purchased and the Nurse Manager had taken it to another center to get the required inspection of the new equipment completed. Within approximately one hour, the mechanical ventilator was brought back to the center and the Nurse Manager stated there was no back up for the ventilator and this was the reason it was not in the center.	Q 016			
Q 019	416.45 MEDICAL STAFF The medical staff of the ASC must be	Q 019			

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Q 019	Continued From page 13 accountable to the governing body. This CONDITION is not met as evidenced by: The center failed to ensure the medical staff was accountable to the governing body (Q019); failed to ensure members of the medical staff were legally and professionally qualified for the positions to which they were appointed and for the performance of privileges in accordance with recommendations from qualified medical personnel (Q020); failed to ensure reappraisals were completed as specified by the governing body (Q021).			Q 019			
Q 020	<p>The cumulative effect of the systemic practice resulted in the failure of the center to ensure all physicians were qualified to provide statutory mandated patient care.</p> <p>416.45(a) MEMBERSHIP AND CLINICAL PRIVILEGES</p> <p>Members of the medical staff must be legally and professionally qualified for the positions to which they are appointed and for the performance of privileges in accordance with recommendations from qualified medical personnel.</p> <p>This STANDARD is not met as evidenced by: Based on interview and document review, the center failed to complete a primary source verification that the medical staff was professionally qualified to practice at the ASC (ambulatory surgery center) and failed to appoint and grant privileges for 2 of 5 physicians (#3, #3).</p> <p>Findings include:</p> <p>Document Review/Interview</p> <p>1. The Governing Body minutes were reviewed</p>			Q 020			

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Q 020	<p>Continued From page 14</p> <p>and there was no evidence the medical staff had been appointed and granted privileges approved by the Governing Body.</p> <p>2. Each of the five physician's files were reviewed and there was no primary source verification from the National Practitioner's Data Bank obtained for any of the five physician's practicing at the center.</p> <p>3. Physician #3 had no evidence in the file that delineation of privileges were granted or the date specified when privileges were granted as there was no letter in Physician #3's file or evidence within the Governing Body minutes of this occurring.</p> <p>4. The Medical Staff By Laws were reviewed and signed on 3/3/08. Article 4, Section 4.03-Appointment specified "The Board of Directors shall appoint to the medical staff.....such physicians and other licensed practitioners who:meet the qualifications set forth in the medical staff by laws, reviewed by the Board of Directors and voted on by the Board of Directors of the corporation for consideration of reinstatement..."</p> <p>On 4/22/08 in the morning, an interview with the Nurse Manager revealed Physician #3 was hired recently (date not specified, but sometime in March, 2008 per the Nurse Manager) and was practicing at the center. Physician #3's credentialing lacked documented evidence dileanation of privileges was granted and completed by the Board of Directors as specified in the Medical Staff By Laws. The credentialing file included faxed credentialing documents from a local hospital and the Nurse Manager stated most all the documents in the physician</p>	Q 020			

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Q 020	Continued From page 15 credentialing files were copies from the local hospital where the physician had been formally credentialed with primary source verifications. There was no evidence primary source verification was obtained by the ASC. The Nursing Manager stated the National Practitioner Data Bank was not queried or other primary source verification obtained. Per the Nurse Manager, the ASC required the physician be on staff at a local hospital and properly credentialed at the hospital and then provide copies from this local hospital to the ASC. The Nurse Manager stated during their recent accreditation survey they received information from the accreditation body that credentialing was not being done properly with primary source verification. 5. Review of physician #1's credentialing file revealed the last date of re-application of privileges was granted on 8/11/04. The next re-application was due on 8/11/07; however, no privilege status was documented following this date. On 4/22/08 at 3:40 PM, the Nurse Manager acknowledged the credentialing file lacked documented evidence of the privileges granted to the physician.	Q 020			
Q 021	416.45(b) REAPPRAISALS Medical staff privileges must be periodically reappraised by the ambulatory surgical center. The scope of procedures performed in the ASC must be periodically reviewed and amended as appropriate. This STANDARD is not met as evidenced by: Based on interview and document review, the center failed to complete reappraisals every three years as specified by the Governing Body	Q 021			

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Q 021	Continued From page 16 for 2 of 6 physician's (#1, #2) Findings include: Document Review Physician #1 and #2 were due for reappraisal of privileges in 8/07 and there was no evidence the reappraisals were completed within the credentialing file or the Governing Body Minutes. Interview During an interview with the Nurse Manager on 4/22/08 in the afternoon, it was revealed appointments and reappointments were not discussed as a regular agenda item or part of the Governing Body Minutes. The Nurse Manager stated credentialing was an internal process and reappointments were done every three years as specified by the Governing Body/Medical Staff By Laws, however, evidence Physician #1 and #2 completed this process by 8/07 was unable to be found. Letters of reappointment for the other physician's were found within the credentialing files and were granted every three years.	Q 021			
Q 026	416.47(a) ORGANIZATION The ambulatory surgical center must develop and maintain a system for the proper collection, storage, and use of patient records. This STANDARD is not met as evidenced by: Based on observation, the center failed to properly store medical records assuring confidentiality. Findings include:	Q 026			

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Q 026	Continued From page 17 During the center tour on 4/21/08 in the morning, it was observed the ASC (ambulatory surgery center) medical records were stored within the clean utility room. The clean utility room door had no lock on the door. The medical records cabinet had a lock, but the cabinet was unable to be closed or locked due to the volume of records stored on the shelves which protruded out making it impossible to close the cabinet. There were other items stored in front of the cabinets; i.e., boxes, oxygen tanks and other debris, making it difficult to lock or secure the medical records to assure confidentiality of the files.	Q 026			
Q 027	416.47(b) FORM AND CONTENT OF RECORD The ambulatory surgical center must maintain a medical record for each patient. Every record must be accurate, legible, and promptly completed. Medical records must include at least the following: o Patient identification o Significant medical history and results of physical examination o Pre-operative diagnostic studies (entered before surgery), if performed o Findings and techniques of the operation, including a pathologist's report on all tissues removed during surgery, except those exempted by the governing body. o Any allergies and abnormal drug reactions o Entries related to anesthesia administration o Documentation of properly executed informed patient consent o Discharge diagnosis. This STANDARD is not met as evidenced by: Based on record review, the center failed to specify if the patient had any allergies to	Q 027			

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Q 027	<p>Continued From page 18</p> <p>medications for 2 of 20 patients (#11, #14) and failed to ensure the medical records were complete and accurate for 4 of 20 patients (#1, #3, #6, #20).</p> <p>Findings include:</p> <p>1. Patient #11 and #14 had nothing written on the "Allergy sticker" on the front of the chart. This information was left blank and did not specify the allergy information.</p> <p>On 4/21/08 during patients' medical record review it evidenced the following:</p> <p>2. Review of Patient #6's medical record evidenced a filed medical history form without the patient's name, time or date. It indicated the patient was taking Aspirin and had a past surgery for TURP (transurethral resection of the prostate). It listed two medications on the form Levvothroxine and Lisinopril. The allergies section was blank.</p> <p>3. There was no pathology report in Patient #20's medical record. The patient had a colonoscopy on 3/21/08 with a specimen collected.</p> <p>4. Review of the nurse's notes evidenced Patient #3 had a sigmoid polyp and "other" collected on 4/21/08. In the "Pathology" section "polyp" was checked mark and sigmoid was hand written next to it. Under "Specimen sent to lab" the section was left blank. Review of the patient's "Esophago Gastro Duodenoscopy Report" evidenced under the "Plan" section that a pathology report was pending. A biopsy was performed on 4/21/08 but the result of the pathology report was still missing in the patient's chart.</p>	Q 027			

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Q 027	Continued From page 19 5. Review of patient #1's medical record evidenced that the patient had a colonoscopy on 3/27/08. A sigmoid polyp was removed with a specimen collected. There was no pathology report located in the patient's medical record. On 4/22/08 at 3:40 PM, Patient #1, #3, #6 and #20's medical records were reviewed with the Nurse Manager. The Nurse Manager concurred Patient #6's information was missing on the medical history form. The Nurse Manager indicated the pathology reports were missing for Patient #1, #3 and #20.	Q 027			
Q 030	416.48(a) ADMINISTRATION OF DRUGS Drugs must be prepared and administered according to established policies and acceptable standards of practice. This STANDARD is not met as evidenced by: Based on observation and interview, the center failed to secure medications in a medication refrigerator located in a patient area. Findings include: Observation During the center tour on 4/21/08 in the morning, a medication refrigerator in the pre-operative area was unsupervised, unlocked and contained vials of Insulin and Tuberculin for administration. Interview During interview with the Nurse Manager on 4/21/08 in the morning, the patient area was often left unsupervised and was a changing area for the patients. There were many chairs and equipment	Q 030			

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Q 030	Continued From page 20 stored in this area due to the limited storage space in the center and because the refrigerator was located behind the stored items, the Nurse Manager did not believe this created any risk to patient safety and management of the medications.	Q 030			